THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

April 2015

Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries

WHAT PRIOR EXPERIENCE DID HEALTH PLANS AND STATES HAVE WITH CAPITATED ARRANGEMENTS?

Prepared by:

Rivka Weiser and Marsha Gold
Mathematica Policy Research

Table of Contents

List of Tables i

Executive Summary ii

Introduction 1

Existing Managed Care Options for Dually Eligible Beneficiaries 1

An Overview of the Financial Alignment Initiative 2

How Managed Care Contracts were Developed For The Demonstrations 3

The State Context of the Demonstrations 5

Focus of State Demonstrations 5

Previous Managed Care and Dual Eligible Experience in Demonstration States 9

Medicare Advantage Experience 11

Medicaid Managed Care Experience 11

Experience with Specific Relevant Integration Programs 12

Health Plan Selection for Demonstrations 16

Health Plan Background and Experience 17

Experience of Participating Health Plans in Demonstration States Operational in 2014 17

Experience of Participating Health Plans in Demonstration States Beginning in 2015 22

Available Information on Quality Ratings of Participating Health Plans 24

Discussion 27

Appendix A: Reconciling Differences Between Medicare and Medicaid Requirements in the Demonstration 28

Endnotes 32

List of Tables

Table ES-1: Comparison of Plan and State Experience Across States with Operational Financial Alignment Demonstration for Dually Eligible Beneficiaries prior to January 2015

Table ES-2: Comparison of Plan and State Experience Across States with Financial Alignment Demonstrations for Dually Eligible Beneficiaries Beginning in 2015

Table 1: Overview of State Dual Eligible Capitated/Administrative Alignment Demonstrations Approved by CMS

Table 2: Number of Dually Eligible Beneficiaries and Capitated/Administrative Demonstration Enrollment, by State

Table 3: Prior Enrollment in Medicare Advantage and Comprehensive Risk-Based Medicaid Managed Care, by State

Table 4: State Experience with Integrating Medicare/Medicaid, Medicaid Managed Long-Term Services and Supports (MLTSS), and Demonstration Contracting, by State

Table 5: Selected Organizational Characteristics and Prior Experience of Capitated Demonstration Health Plans, by State

Table 6: Prior Experience of Capitated Demonstration Health Plans in Demonstration States Planned to Begin Operations in 2015, by State

Table 7: Quality Ratings of In-State Health Plans Related to Demonstration Health Plans, by State

Appendix

Table 1: Selected Differences in Medicare Advantage and Medicaid Managed Care Requirements

Executive Summary

Individuals who are dually eligible for Medicare and Medicaid ("dually eligible beneficiaries") constitute a diverse population with extensive and varied needs for services, requiring careful coordination of the benefits covered across the two programs. The Financial Alignment Initiative was developed by the Federal Coordinated Health Care Office in the Centers for Medicare and Medicaid Services (CMS) in an effort to work with states to improve the coordination of all Medicare and Medicaid covered benefits, and enhance the care provided to dually eligible beneficiaries.

Most states participating in the initiative are pursuing a capitated managed care model, which is the focus of this brief. In these capitated financial alignment demonstrations, health plans contract with the state and CMS (a three-way contract) to provide both Medicare and Medicaid benefits to dually eligible beneficiaries. This brief reviews the demonstration projects established in 10 states — the nine states that had three-way contracts by December 2014 for capitated financial alignment demonstrations (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia), and one state that is administratively aligning Medicare and Medicaid (an administrative alignment demonstration) using its existing managed care model (Minnesota). Five of these states' demonstrations (California, Illinois, Massachusetts, Ohio, and Virginia), as well as the Minnesota administrative alignment demonstration, were operational as of December 2014.

This brief reviews the prior experience in states participating in the initiative and in the health plans in operating Medicare Advantage or Medicaid Managed Care (MMC) plans within the states, particularly those with financial alignment demonstrations currently underway. The prior experience of states and health plans provides a foundation for understanding the existing infrastructure for implementing these demonstrations. States that are experienced in working with managed care plans, even if for other populations, are more likely to have expertise in setting capitation rates, negotiating terms for the contracts with plans, monitoring the quality of care, and overseeing the enrollment process. States' prior experience may also be a proxy for how familiar beneficiaries and providers in the state are with similar capitated programs. Health plans with prior experience in providing coverage for dually-eligible beneficiaries (or for those with just Medicare or Medicaid) are more likely to be familiar with the significant needs of this population, and the rules pertaining to various aspects of operating a plan (e.g., appeals and grievances, network requirements, enrollment procedures) and benefits that could ease implementation of the demonstration.

Key Findings

State Experience with MMC for Dually Eligible Beneficiaries and with Integrating Medicare and Medicaid. The 10 states participating in the demonstration using a capitated managed care model differ considerably in their prior experience in managing care for dually eligible beneficiaries. Four of the nine demonstration states (California, Massachusetts, New York, and Texas) provided some Medicaid services to dually eligible beneficiaries through capitated MMC and had programs that integrated Medicare and Medicaid services for dually eligible beneficiaries prior to the demonstration; the extent of experience differed across these states. Massachusetts had a larger and more fully integrated program than the other three states. Five of the demonstration states (Illinois, Michigan, Ohio, South Carolina, and Virginia) did not previously contract with health plans to integrate Medicare and Medicaid benefits for dually eligible beneficiaries and dually eligible beneficiaries in these states were not enrolled in capitated MMC before these states began to develop their demonstrations. Minnesota, which is implementing an administrative demonstration only, is building upon its prior program that integrated Medicare and Medicaid services for dually eligible beneficiaries.

Health Plans Participating in the Initiative. Twenty-nine health plans operated by 24 organizations participated in the five states with operational financial alignment demonstrations beginning in 2013 or 2014; another 38 health plans were scheduled to participate in the other state demonstrations beginning in 2015 (See Table ES-1 and Table ES-2 for a summary). Because health plan participation is not set until implementation begins, our analysis, conducted in the fall of 2014, focused most extensively on health plans in the five states with operational demonstrations at that time.

Health Plan Experience with Medicare Advantage and Medicaid Managed Care. Most, but not all, health plans in state demonstrations operational in 2014 had prior experience within the states with either Medicaid managed care and/or Medicare Advantage health plans of some type. Of the 29 health plans, seven had no previous in-state Medicaid enrollment (mostly in Illinois, in which organizations developed Medicaid plans at around the same time as the demonstration). Four of the 29 organizations had no in-state Medicare Advantage enrollment, though two of those had Medicare Advantage plans in other states.

Looking across all the participating states, most health plans (50 out of 67 plans) have some experience managing Medicare benefits in the state in which they would be operating a demonstration plan, either through regular Medicare Advantage plans or Special Needs Plans for dually eligible beneficiaries (D-SNPs). However, 17 of the health plans, some of which had Medicare Advantage plans in other states, have no in-state experience managing Medicare benefits. In particular, most of the demonstration plans in South Carolina and many of the plans in New York lack in-state Medicare experience. In New York, this lack of experience may be attributable to the state's selection of plans based on their experience managing long-term services and supports (LTSS) in Medicaid. In South Carolina, enrollment in Medicare Advantage plans has historically been relatively low, and fewer organizations have any experience with Medicare Advantage relative to other states with higher Medicare Advantage enrollment. In states with prior enrollment of dually eligible beneficiaries in capitated MMC, the demonstrations are contracting with companies that also operate health plans in their existing Medicaid programs that serve dual eligible and/or include managed LTSS.

National Affiliations and Profit Status. Of the 29 plans in states with demonstrations that were operational before 2015, 10 were local (mainly in California and Massachusetts), 9 were affiliated with four national firms operating in more than one demonstration state (Centene, Humana, Molina, and Anthem), and 10 with other organizations. Twelve operated on a nonprofit basis (all 10 local plans and two others — Blue Cross Blue Shield of Illinois and CareSource) and the other 17 on a for-profit basis. In the four demonstration states beginning operations in 2015 (Michigan, New York, South Carolina, and Texas), the participating health plans are mostly operated by large, multi-state, for-profit organizations. New York is the main exception as it has many local, nonprofit, provider-based plans that are also part of its Medicaid Managed Long Term Care (MLTC) program.

Plan Quality Ratings. Among demonstrations operational in 2014, plans in Massachusetts have high ratings for their Medicare and Medicaid product lines, whereas almost all of California's health plans have relatively low Medicaid ratings. Because of limited prior enrollment, there are few Medicaid quality ratings for Illinois health plans (with one exception). The health plans participating in the Ohio and Virginia demonstrations generally have average quality ratings.

Discussion

The findings of this study suggest that in states and health plans engaged in capitated financial alignment demonstrations, there is considerable variation in the relevant prior experience brought to the demonstration. In some states, such as Massachusetts and California, plans participating in the demonstrations have had prior experience with dually eligible beneficiaries in both Medicare and Medicaid capitated arrangements. However, in other states, plans, beneficiaries, and providers have had minimal exposure to capitated arrangements for Medicaid or Medicare. In these latter states, plans will need to ramp up the knowledge, provider networks, and infrastructure that will be needed to address the complex needs of dually eligible beneficiaries. States with relatively little experience with capitated arrangements for Medicaid populations (including beneficiaries dually eligible for Medicare and Medicaid) may face greater challenges in setting payment rates, negotiating contracts with plans, and overseeing the care provided by plans in that state. Health plans with relatively little experiences may face greater challenges in developing new provider networks, tailoring care management models for dually eligible beneficiaries, and providing integrated care for a high-need population through capitated arrangements. Even in states with a fair amount of experience with managed care, some health plans are more oriented toward Medicaid's low income families than with Medicare beneficiaries, which could pose challenges as these demonstrations get underway. How well all this is accomplished is important because the Financial Alignment Initiative seeks to improve care for dually eligible beneficiaries, a population widely recognized as having extensive needs that are challenging to address and not necessarily well addressed by the current health care system, with its division of benefits between Medicare and Medicaid.

Table ES-1. Comparison of Plan and State Experience Across States with Operational Financial Alignment Demonstration for Dually Eligible Beneficiaries prior to January 2015					
	California	**Illinois**	**Massachusetts**	**Ohio**	**Virginia**
Total Number of Plans	**10**	**8**	**3**	**5**	**3**
Number of plans with in-state experience managing Medicare benefits, including Medicare Advantage non-SNPs or D-SNPs	9 3 non-SNPs; 9 D-SNPs	6 6 non-SNPs; 3 D-SNPs	3 2 non-SNPs; 3 D-SNPs	5 2 non-SNPs; 4 D-SNPs	2 2 non-SNPs; 1 D-SNPs
Number of plans with any in-state experience managing Medicaid benefits for dually eligible beneficiaries	10	0	3	0	0
Number of nonprofit plans	6	1	3	1	1
Number of plans affiliated with national firms operating demonstrations in 2+ states	2	5	0	5	2
Relative Medicaid quality ratings	Low (generally)	Not available (generally)	High (generally)	Average (generally)	Average (generally)
Relative Medicare quality ratings for D-SNPs	Average (generally)	Not available (generally)	High (generally)	Not available (generally)	Average (generally)
State Experience					
Prior to demonstration, state contracted with health plans to provide some Medicaid benefits to dually eligible beneficiaries?	Yes	No	Yes	No	No
Prior to demonstration, state contracted with health plans to integrate Medicare and Medicaid benefits to dually eligible beneficiaries?	Yes	No	Yes, but only for seniors	No	No

Source: Authors' analysis, 2015. See tables 3 through 7 for all data sources.

Table ES-2. Comparison of Plan and State Experience Across States With Financial Alignment Demonstrations for Dually Eligible Beneficiaries Beginning in 2015				
	Michigan	New York	South Carolina	Texas
Total Number of Plans	7	22	4	5
Number of plans with any in-state experience managing Medicare benefits, including Medicare Advantage plans and D-SNPs	6	15	1	5
Number of plans with any in-state experience managing Medicaid benefits for dually eligible beneficiaries	5	22	0	5
Number of plans affiliated with national firms operating demonstrations in 2+ states	2	2	3	5
State Experience				
Prior to demonstration, state contracted with health plans to provide some Medicaid benefits to dually eligible beneficiaries?	No*	Yes	No	Yes
Prior to demonstration, state contracted with health plans to integrate Medicare and Medicaid benefits to dually eligible beneficiaries?	No	Yes	No	Yes

Source: Authors' analysis, 2015. See tables 3 through 7 for all data sources.

Note: * Michigan began including some dually eligible beneficiaries in Medicaid managed care after the 2011 date of the CMS enrollment data used for this report, during the time Michigan was planning its demonstration.

Introduction

Individuals dually eligible for Medicare and Medicaid are a diverse population, with characteristics and care needs that create vulnerabilities and account for a disproportionate share of health care spending.[1] About 40 percent are low-income, under age 65, and disabled, including a majority with significant mental health or substance abuse service needs, and many with extensive long-term services and supports (LTSS) needs. The others are low-income elderly individuals, many of whom have multiple chronic conditions or are frail, and may require LTSS.[2] Many of these individuals have a diversity of needs and require complex care management that leverages a wide variety of services and provider types.

Medicare is the primary payer for acute care services required by dually eligible beneficiaries, whereas Medicaid provides additional benefits not covered by Medicare (primarily LTSS) and covers cost sharing and premiums associated with the Medicare program.[3,4] Although effective care typically requires coordinating the benefits covered by these different programs, the means for doing so have been limited historically, with each program operating independently.[5] Beneficiaries generally have received services paid on a fee-for-service basis, with no single entity responsible for seeing that services are coordinated appropriately to meet the needs of individual beneficiaries.

Existing Managed Care Options for Dually Eligible Beneficiaries

Medicare Advantage is the main managed care option within Medicare. Although all beneficiaries may enroll, there have been limited incentives for dually eligible beneficiaries to do so because they have typically received the extra benefits offered by Medicare Advantage plans (such as lower cost-sharing and limited benefits for vision and dental services) through Medicaid. To better serve their needs, the Medicare Modernization Act of 2003 allowed for the development of Dual Eligible Special Needs Plans (D-SNPs) that could be tailored to those dually eligible for Medicare and Medicaid. D-SNPs have recently been required to have contracts with state Medicaid agencies (in addition to Medicare) and coordinate delivery of Medicare and Medicaid benefits. However, states have little financial incentive to integrate benefits unless Medicaid LTSS are included in the benefit package because Medicaid coverage of acute care benefits is very limited for dually eligible beneficiaries).

Integration is less challenging for states with prior experience in aligning Medicare and comprehensive Medicaid benefits. While most D-SNPs provide only Medicare benefits in their capitated benefit packages, Fully Integrated Dual Eligible (FIDE) SNPs are D-SNPs that coordinate Medicare and Medicaid services and contract with states to provide Medicaid services, including LTSS, on a risk basis. Demonstration states that have implemented FIDE SNPs (California, Massachusetts, Minnesota, and New York) have had more experience with integration for dually eligible beneficiaries than others, as discussed later in this brief.

Within Medicaid, comprehensive risk-based managed care is the broadest-based managed care program.[6] Historically, these programs were developed to serve low-income families and children. However, programs have been expanded in some states to cover those eligible for Medicaid based on disability, and health plans have had to adjust their provider networks and care management tools to address this population's needs. Typically, these programs have been restricted to Medicaid-only individuals because of the challenges in coordinating benefits across Medicare and Medicaid. When state Medicaid programs focused on managed care

for dually eligible beneficiaries, they generally did so primarily to coordinate and limit cost growth in LTSS, which are state responsibilities.[7]

The health plans participating in Medicare and Medicaid are not necessarily the same plans, and therefore health plans serving dually eligible beneficiaries may not already have experience serving members under each program.[8] Medicare Advantage plans are more likely to have had experience in managing acute care benefits for both aged and disabled beneficiaries, whereas Medicaid health plans generally have managed benefits for low-income families and children and, in some states, acute care services and/or LTSS for adults with disabilities. Enrollment in health plans is voluntary in Medicare but can be mandated in Medicaid if states meet federal terms and conditions.

An Overview of the Financial Alignment Initiative

With the goal of better coordinating care financed by the Medicare and Medicaid programs for dually eligible beneficiaries, the Affordable Care Act authorized the creation of a new Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS). Its goal is to enhance dually eligible beneficiaries' access to benefits, simplify and make more consistent the requirements and processes used across the two programs, better coordinate the programs' benefits, and enhance the quality and cost-effectiveness of care.[9]

The Financial Alignment Initiative is one major strategy being pursued to achieve these goals. Under the initiative, states were solicited to participate in a partnership with the federal government to develop demonstrations to better align care for dually eligible beneficiaries across Medicare and Medicaid.[10] States were provided with two basic models: a Capitated Managed Care Model and a Managed Fee-for-Service Model.[11] The initial design of the financial alignment demonstrations was very ambitious, with the expectation that, by 2012 and 2013, a large number of states would be actively engaged in operational programs that served large numbers of individuals; this expectation generated some concern about the wide scope and rapid pace of change sought and the potential disruptions to services for vulnerable beneficiaries.[12] Although 26 states initially expressed interest in some form of the demonstration involving either model, at least 11 later withdrew and the time frame for other states was delayed.[13]

This brief focuses specifically on the capitated managed care model being pursued under the demonstration. The model involves contracting with health plans on a capitated basis to provide coordinated benefits across Medicare and Medicaid. Some experts believe that a managed care approach offers the greatest potential to modify fee-for-service incentives (which can incentivize provision of unnecessary services) and achieve better coordination of services and across benefits covered in different programs. Capitated payment, by its nature, focuses on the totality of care for people enrolled in the health plan. Conceptually, capitation provides incentives to manage care in ways that prevent, where feasible, avoidable conditions or complications that can be expensive to treat and harmful to the health of the enrollee. Because they are responsible for all the covered benefits received by this population, managed care plans must develop provider networks and other policies that support adequate access to covered by their contracts with Medicare and Medicaid. Contracts with these payers in turn include requirements that plans must meet and stipulate processes of oversight. They typically also require reporting of performance metrics that reflect care for the populations they serve. Such

requirements are harder to implement in fee-for-service and are especially important in caring for the dual eligible population.

There are, however, also inherent risks that capitation's financial incentives will lead to underservice and suboptimal care, particularly if contracts are signed with plans and associated providers that have limited experience in providing services for the dually eligible population. Their provider networks may not necessarily include the full range of specialized services that dually eligible beneficiaries are likely to require (such as specific types of substance abuse, mental health, and LTSS providers); also, care management tools developed for a healthier population may not be adequate for dually eligible beneficiaries. There are concerns regarding potential trade-offs between cost containment and quality of care, and the potential that dually eligible beneficiaries in the demonstration could be treated differently from other Medicare beneficiaries, particularly with regard to beneficiary choice, protections, and oversight.

States are using so-called "passive" enrollment for the demonstrations, notifying beneficiaries about their pending enrollment in a demonstration health plan but allowing them to opt out at any time (effective monthly) before or after enrollment. Beneficiaries may be passively enrolled in a plan that does not include all of their providers in its network. Therefore, in order to avoid service disruptions for beneficiaries in the demonstrations, it is particularly important that health plans' provider networks match the needs and service patterns of the population. (Appendix A summarizes differences across the programs in more detail.)

The balance between risks and rewards to consumers and other stakeholders depends on the adequacy of the requirements in the managed care contracts that define the health plan's responsibilities, the experience and quality of the health plans implementing them, and the effectiveness of shared oversight by the federal government and states. This brief does not examine the capacity of states and the federal government to oversee the demonstrations. However, capacity for demonstration oversight depends on a number of factors, including past experience with similar programs. State background is particularly important because the design of the financial alignment demonstration was structured to encourage states to design and tailor the demonstration to the needs of the state, and states have considerable responsibility (jointly with CMS) for both implementation and overseeing the way they work.[14]

How Managed Care Contracts were Developed For The Demonstrations

The managed care models being implemented by states evolved through a multi-step process of negotiation, first between states and the federal government, and later between the federal government, states, and health plans. During the first half of 2012, states submitted proposals to CMS, and many also tentatively selected health plans at around the same time. CMS then negotiated individual memoranda of understanding (MOUs) with states, the first of which was signed with Massachusetts in August 2012. Based on the MOU, the federal government and the state then developed a three-way contract between CMS, the state Medicaid agency, and participating health plans, laying out details of terms, requirements, and payment rates. The nature of this process influenced the final composition of participating health plans.

The development of these contracts and implementation of the demonstrations required harmonizing Medicare and Medicaid timelines and requirements in areas such as plan selection, provider network adequacy, quality oversight, and appeals processes. Reconciling these requirements contributed to delays and

some attrition of participating states and health plans when agreement could not be reached on key terms. Additionally, the initiative generated national controversy about its scale and speed, and consumer advocacy groups and others expressed concern over various aspects of it, both nationally and in individual states.[15] The delays allowed for time to address various complexities in demonstration development, but also caused uncertainty among providers, beneficiaries, and stakeholders about what would roll out and when.

In health plan interviews in 2012, plan executives expressed concerns over how well disparate requirements across the programs would be reconciled, and some noted that, although states were negotiating with the federal government, the plans had relatively little information available on key parameters, such as rates.[16] Because many critical details important to health plans (such as payment rates and requirements) were not known at the start, some health plans that initially were selected later withdrew in the course of negotiations on the three-way contract.

Although all participating health plans were required to meet both Medicare and Medicaid requirements, the demonstration allows state Medicaid programs to "passively enroll" dually eligible beneficiaries into health plans that cover their Medicare benefits as long as beneficiaries can opt out at any time. Plans under a Medicare enrollment or marketing sanction are not eligible for any demonstration enrollment, and CMS rules prohibit companies with low past performance in Medicare Advantage from receiving passive enrollment in their demonstration health plans.[17]

The State Context of the Demonstrations

Within the 10 states implementing health plan-based demonstrations, there are diverse levels and types of previous experience with relevant managed care and care coordination efforts (such as D-SNPs, capitated MMC for various populations, Medicaid managed long-term services and supports [MLTSS], and other Medicare/Medicaid integration efforts). States' prior work in these areas can help in assessing state capacity to implement and oversee the demonstration, providing insight into why and how the state is implementing its demonstration, and what experience the health plans, beneficiaries, and providers in the state have regarding relevant capitated programs.

Focus of State Demonstrations

Table 1 summarizes selected characteristics and the current state of health plan-based demonstrations in 10 states — the nine state demonstrations that had three-way contracts for capitated financial alignment demonstrations by December 2014, and one state with an administrative alignment demonstration.[18] All of the state demonstrations are focused on adults dually eligible for Medicare and Medicaid (only a very small percentage of dually eligible beneficiaries are children), but some limit eligibility by age or other conditions. Regarding age, Massachusetts's demonstration includes only dually eligible beneficiaries under age 65 (the state already had an integrated program for dually eligible adults ages 65 and older), whereas both Minnesota's and South Carolina's demonstrations include only the elderly (65+). New York and Texas restrict eligibility to a subset of enrollees with specific LTSS requirements or use patterns, which mirror eligibility requirements in their existing related state MLTSS programs (Managed Long Term Care for New York and STAR+PLUS for Texas). Minnesota's demonstration is unique, in that it aligns specific administrative functions within its existing program for dually eligible beneficiaries ages 65 and older, without financial alignment.

State demonstrations vary in their scope, reflecting in part the differences in the size and diversity of states and existing managed care programs. Whereas only two demonstrations are fully statewide (South Carolina and Minnesota), some other states include large numbers of counties that they tend to group into regions to facilitate management (Illinois, Michigan, Ohio, Virginia). In contrast, California, New York, and Texas are very large and diverse states that have chosen to focus their demonstrations on particular regions (seven counties mainly in southern California, seven counties in and around New York City, and six largely urban counties in Texas). Due to the urban focus of various states, the demonstrations cover many large population centers (such as Los Angeles, Chicago, Boston, Detroit, New York City, Houston, Dallas, and San Antonio). Given that both Medicare Advantage and MMC have higher penetration rates in urban areas,[19] it is not surprising that many demonstrations melding the two programs also focus on key urban areas, which also are the areas where beneficiaries, including those dually eligible for Medicare and Medicaid, are more likely to live.

Table 1. Overview of State Dual Eligible Capitated/Administrative Alignment Demonstrations Approved by CMS				
	Population and Area		Time Line	
State	Dually Eligible Beneficiaries Target Population[a]	Geographic Area[a]	Memorandum of Understanding Date[b]	Initial Enrollment Date[b]
CA	Adults	7 counties	3/2013	4/2014
IL	Adults	21 counties grouped into 2 regions	2/2013	3/2014
MA	Adults under 65	8 full and 1 partial counties	8/2012	10/2013
MI	Adults	25 counties grouped into 4 regions	4/2014	3/2015
MN[c]	Adults 65+ enrolled in the Minnesota Senior Health Options program	Statewide	10/2013	9/2013
NY	Adults who require particular types of LTSS[d]	8 counties	8/2013	1/2015
OH	Adults	29 counties grouped into 7 regions	12/2012	5/2014
SC	Adults 65+ who live in the community at the time of enrollment	Statewide	10/2013	2/2015
TX	Adults who qualify for Supplemental Security Income (SSI) or Medicaid waiver HCBS	6 counties	5/2014	3/2015
VA	Adults	104 localities grouped into 5 regions	5/2013	4/2014

Sources:

[a] Musumeci M, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," Washington, DC: Henry J. Kaiser Family Foundation, July 2014. http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/. See Appendix of Musumeci, 2014 for subpopulations excluded from each state's demonstration.

[b] Demonstration time lines from CMS financial alignment demonstration websites; Michigan updated time line from "Michigan Announces Implementation Timeline Change for MI Health Link." November 2014. http://www.michigan.gov/mdch/0,4612,7-132-63157_64754-342151--,00.html; California updated geography from calduals.org, "Alameda and Orange County Updates." November 14, 2014. http://www.calduals.org/2014/11/14/alameda-orange-county-updates/.

Notes: Washington state is excluded from the table because the state decided (in February 2015), not to pursue its previously planned capitated financial alignment demonstration due to health plan withdrawal. It has had a managed fee-for-service (MFFS) demonstration since 2013. Colorado also has a managed fee-for-service (MFFS) demonstration.

[c] Minnesota's demonstration is administrative only, with no financial alignment. Existing plans' contracts were amended to include the terms of the demonstration.

[d] New York is including adult dually eligible beneficiaries who receive facility-based LTSS, who are eligible for a Nursing Home Transition & Diversion home and community-based waiver services, or require more than 120 days of community-based LTSS.

Of the states with capitated financial alignment demonstrations, five had enrollment in 2014 (California, Illinois, Massachusetts, Ohio, and Virginia). However, enrollment has been slow to build relative to initial targets; only two states with capitated financial alignment demonstrations (Illinois and Ohio) had about 50 percent or more of their target population enrolled by March 2015 (see Table 2). In part, low enrollment reflects delays in the start of passive enrollment and, in some states (such as California), it reflects significant percentages of eligible beneficiaries opting out of enrollment.[20] Four states with capitated financial alignment demonstrations (New York, Michigan, South Carolina, and Texas) began voluntary enrollment in early 2015.

The 10th state (Minnesota) is in a unique situation because it is building on its existing integration efforts through an administrative alignment demonstration. The demonstration integrates administration, oversight, and other features of its existing program involving separate Medicaid and D-SNP contracts for health plans (such as streamlining appeals and grievances, establishing state roles in oversight of the D-SNPs, and establishing processes for coordination of integrated member materials). Existing contracts in Minnesota's integration program for dually eligible beneficiaries were modified to include the terms of the administrative alignment demonstration. Health plans continue to be paid separately by Medicare and Medicaid on a capitated basis, with no opportunity for the state and federal governments to share in savings (as there is in the capitated financial alignment demonstrations).[21]

Table 2. Number of Dually Eligible Beneficiaries and Capitated/Administrative Demonstration Enrollment, by State				
State	Total (2010)[a, d]	Estimated Eligible for Demonstration[b]	Enrolled in Demonstration (as of March 2015)[c, e]	Percentage of Estimated Eligible Who Are Enrolled (as of March 2015)
CA	1,253,000	456,000	133,407	29%
IL	346,000	135,825	63,575	47%
MA	249,000	90,240	17,751	20%
MI	287,000	100,000	0	0%
MN	138,000	36,000	36,487[f]	100%
NY	796,000	170,000	666	0%
OH	332,000	115,000	66,826	58%
SC	152,000	53,600	1,502	3%
TX	654,000	168,000	35	0%
VA	182,000	78,600	27,029	34%

Sources:

[a] Table 7 of MedPAC [Medicare Payment Advisory Commission] and MACPAC [Medicaid and CHIP Payment Access Commission], "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," January 2015. http://www.medpac.gov/documents/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf?sfvrsn=2

[b] Musumeci M, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," Washington DC: Henry J. Kaiser Family Foundation, July 2014.

[c] CMS Medicare Advantage Monthly Enrollment data, March 2015 (Monthly Enrollment by Plan for financial alignment demonstration states and SNP Comprehensive Report for Minnesota).

Notes:

[d] Dually eligible beneficiaries receiving full or partial Medicaid benefits.

[e] Monthly Medicare Advantage enrollment reports do not include data from plans that have fewer than 10 enrollees.

[f] Minnesota's demonstration is administrative only, with no financial alignment. Existing plans' contracts were amended to include the terms of the demonstration; thus, all beneficiaries in the existing FIDE SNPs are in the demonstration.

Previous Managed Care and Dual Eligible Experience in Demonstration States

Existing work highlights the generally limited experience nationally with managing care for dual eligible populations, and the limitations of statistics available to measure this background.[22] In Table 3, we summarize available statistics on Medicare Advantage and MMC enrollment, both overall and for those dually eligible, by state.

Whereas most demonstration states have had considerable enrollment in Medicare Advantage and MMC in general, their experience varies, especially regarding dually eligible beneficiary enrollment in each program. Five of the demonstration states have had some dually eligible beneficiaries in capitated MMC that integrated Medicare and Medicaid services (California, Massachusetts, Minnesota, New York, and Texas), whereas five other states do not have this experience (Illinois, Michigan, Ohio, South Carolina, and Virginia). In Table 3, states are grouped according to whether they have previously enrolled dually eligible beneficiaries in capitated MMC. This particular grouping of states also is useful for examining other differences among these states and how they have implemented their demonstrations.

Among the five states with prior enrollment of dually eligible beneficiaries in capitated MMC, four had existing FIDE SNPs (California, Massachusetts, Minnesota, and New York).[23] Two of these states (California and New York) have only limited FIDE SNP enrollment, though they also have other relevant in-state experience (to be discussed below). Additionally, Texas has a large managed care program with contractors that have both MMC and D-SNP plans, and coordinate between them. Importantly, this experience with dually eligible beneficiaries and integration impacts the landscape of health plans in a state. An earlier analysis found that, in 2010, these five states each had multiple companies within them that both offered D-SNP plans and had dually eligible beneficiaries in their MMC plans.[24]

The other five demonstration states have had no prior enrollment of dually eligible beneficiaries in capitated MMC (Illinois, Michigan, Ohio, South Carolina, and Virginia). As discussed below, other indicators also indicate that most of these states had less demonstration-relevant experience, such as low D-SNP enrollment. Further, in an analysis of health plan experience in 2010, no companies in these states offered both MMC and Medicare Advantage health plans.[25] However, some companies (including some of those operating demonstration health plans) have more recently entered both the Medicare and Medicaid markets in these states.

Relevant prior experience within all of these states is discussed in further detail below.

Table 3. Prior Enrollment in Medicare Advantage and Comprehensive Risk-Based Medicaid Managed Care, by State						
	Enrollment of Medicare Enrollees in Medicare Advantage			Enrollment of Medicaid Enrollees in Comprehensive Risk-Based Medicaid Managed Care (2011)		
	MA Penetration Rate (2004)[a]	MA Penetration Rate (2014)[a]	Percentage of Dually Eligible Beneficiaries in D-SNPs (2014)[b]	Percentage of all Medicaid Enrollees[c]	Percentage of Blind/Disabled Medicaid Enrollees[d]	Percentage of Dual Eligible Enrollees[c]
National	*12%*	*30%*	*16%*	*51%*	*41%*	*13%*
States in which there is experience with dually eligible beneficiaries in Medicaid managed care						
CA	31%	38%	19%	60%	52%	23%
MA	16%	20%	12%	33%	42%	6%
MN	13%	51%	30%	66%	15%	41%
NY	17%	35%	22%	76%	66%	**1%**
TX	6%	29%	19%	47%	40%	22%
States in which there is no prior experience with dually eligible beneficiaries in Medicaid managed care						
IL	**4%**	16%	**1%**	**8%**	12%	**0%**
MI	**1%**	30%	8%	67%	81%	**0%**
OH	12%	38%	**5%**	75%	63%	**0%**
SC	**0%**	22%	13%	50%	52%	**0%**
VA	**1%**	15%	**1%**	58%	63%	**0%**

Sources:

[a] Henry J. Kaiser Family Foundation, State Health Facts data. "Medicare Advantage Enrollees as a Percent of Total Medicare Population." http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/

[b] Gold M, Jacobson G, Damico A, and Neuman T, "Medicare Advantage 2014 Spotlight: Enrollment Market Update." Washington DC: Henry J. Kaiser Family Foundation, May 2014. http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-enrollment-market-update/

[c] CMS. "2011 Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011." Includes managed care organization (MCO) and health information organization (HIO) enrollment.

[d] Based on analysis by MACPAC of CMS Medicaid Statistical Information System (MSIS) data. Includes Medicaid enrollees who were blind or disabled, eligible for Medicaid only (not Medicare), and enrolled in an HMO for at least one month in 2011. These rates use a different methodology from the other columns in this table. Communication with MACPAC and analysis are on file with the authors.

Notes: All states except Illinois and Minnesota also had small numbers of dually eligible beneficiaries enrolled in PACE, up to 1% of dually eligible beneficiaries. Figures in bold reflect state penetration rates that are particularly low (5% or less for D-SNP or dual eligible enrollment and 10% or less for other penetration rates). Since the most recent 2011 data on MMC penetration, some states have had changes in their Medicaid programs that impact the data. For example, Illinois expanded its Integrated Care Program for aged, blind, and disabled Medicaid enrollees, and is transitioning other Medicaid enrollees to managed care. South Carolina transitioned more of its Medicaid program to MCOs (see South Carolina, "Managed Care Organizational Changes. Explanation of the Organizational Changes," https://www.scdhhs.gov/press-release/managed-care-organizational-changes-explanation-organizational-changes). Additionally, Michigan began to enroll dually eligible beneficiaries in its capitated Medicaid managed care plans.

Medicare Advantage Experience

Demonstration states vary widely regarding the extent to which Medicare beneficiaries had participated in Medicare Advantage (see Table 3). Medicare Advantage penetration rates in 2014 varied from a low of 15 percent (Virginia) and 16 percent (Illinois) to a high of 51 percent (Minnesota) and 38 percent (California). It is difficult to assess Medicare Advantage penetration among people dually eligible for Medicare and Medicaid, as CMS does not provide data on enrollment among such beneficiaries in Medicare Advantage, either by health plan or state (though national Medicare Advantage penetration rates are lower among dually eligible beneficiaries than among those eligible for Medicare only).[26] However, CMS does provide data on enrollment in D-SNPs, a Medicare Advantage program that has specific requirements oriented toward the needs of the dually eligible population. Nationwide, about 16 percent of dually eligible beneficiaries are enrolled in D-SNPs. State D-SNP enrollment signals health plan interest in dual eligible-focused product lines, state past work in contracting with Medicare plans and prior interest in developing integrated programs, and provider and beneficiary experience with managed care, all of which are highly relevant to understanding the demonstration-related background.

The five demonstration states with no previous enrollment of dually eligible beneficiaries in MMC also generally had lower D-SNP enrollment — especially Illinois, Ohio, and Virginia, which had 5 percent or fewer dually eligible beneficiaries enrolled in D-SNPs. Additionally, four of these five states (Illinois, Michigan, South Carolina, and Virginia) had very limited Medicare Advantage enrollments in 2004. This is important, because research generally shows that health plans more mature in their experience with Medicare Advantage tend to score higher on some quality metrics than newer health plans.[27] Among the demonstration states, Illinois and Virginia stand out as having had particularly limited Medicare Advantage and D-SNP penetration. Among the states with previous enrollment of people dually eligible for Medicare and Medicaid in capitated MMC, all except Massachusetts had penetration rates near or above the national average for both Medicare Advantage and D-SNPs. California, Minnesota, and New York each have particularly high levels of enrollment in both Medicare Advantage and D-SNPs.

Medicaid Managed Care Experience

Not surprisingly, because of the state-based nature of the demonstrations, most states pursuing capitated models rely heavily on capitated managed care in their Medicaid program (9 of the 10 had managed care penetration rates of about 50% or more). Table 3 summarizes enrollment in comprehensive risk-based MMC by state, for all Medicaid enrollees, those with disabilities, and dually eligible beneficiaries. While capitated Medicaid managed care penetration rates are generally lower for those with disabilities than for the overall Medicaid population, all demonstration states have enrolled some individuals with disabilities in MMC. Notably, Illinois had particularly limited comprehensive risk-based MMC experience before developing its demonstration — for both Medicaid beneficiaries in general (8%) and those with disabilities (12%). Illinois currently is moving forward rapidly with implementing comprehensive risk-based managed care in Medicaid.

Previous enrollment of dually eligible beneficiaries in capitated MMC has been more limited in some of the demonstration states, and absent in half of them. Among participating states, Minnesota, California, and Texas have the most extensive enrollment, with penetration rates of 41 percent, 23 percent, and 22 percent, respectively; Massachusetts also has some enrollment of dually eligible beneficiaries ages 65 and over in parts of the state (6% penetration);[28] and New York has a small program (with 1% penetration). Other states had no

dually eligible beneficiaries enrolled in capitated MMC (Illinois, Michigan, Ohio, South Carolina, and Virginia). MMC enrollment of dually eligible beneficiaries means different things in different states. In some states, dually eligible beneficiaries are enrolled in Medicaid health plans to receive Medicaid benefits only. However, in other states, some integration of Medicare and Medicaid benefits occurred even before the demonstrations, as discussed next.

Experience with Specific Relevant Integration Programs

Given the focus of the demonstrations, experience with programs that integrate Medicare and Medicaid benefits and programs that manage long-term services and supports for those in Medicaid are particularly relevant. LTSS are the main services covered by Medicaid for dually eligible beneficiaries and are covered (to varying extents) under all states' demonstrations. Historically, states' experience in managing Medicaid LTSS under capitated managed care has been limited. However, more states have been implementing capitated MLTSS in Medicaid recently, though such programs can be challenging to implement and monitor.[29] In Table 4, we summarize demonstration states' existing programs to integrate care for dually eligible beneficiaries and/or provide LTSS under MMC plans; like Table 3, this table groups states according to their previous experience with enrolling dually eligible beneficiaries in capitated MMC.

States that had previous enrollment of dually eligible beneficiaries in capitated MMC also had at least some integration of care for them. Additionally, almost all demonstration states (except Illinois and Minnesota) had some enrollment in Program of All-inclusive Care for the Elderly (PACE).[30] However, PACE enrollment was low in each state (no more than 1% of dually eligible beneficiaries). Aside from PACE, five of the demonstration states had pre-demonstration programs that integrated Medicare and Medicaid benefits for those dually eligible for both programs – some of them with full integration and others with some coordination between MMC plans and D-SNPs.

Table 4. State Experience with Integrating Medicare/Medicaid, Medicaid Managed Long-Term Services and Supports (MLTSS), and Demonstration Contracting, by State						
		Other Pre-Demonstration Program				
	PACE[a]	Program Name	Integration of Medicare and Medicaid[b]	MLTSS	Enrollment (2012)[c]	Demonstration limited to health plans in existing state program?
States in which there <u>is</u> experience with dually eligible beneficiaries in Medicaid managed care						
CA[d]	Yes	SCAN Connections at Home	Full integration	Yes	2,304	Yes. Limited to Medicaid plans with contract in county (with exception of L.A. County).
		CalOptima and Health Plan of San Mateo[e]	Medicaid contractors have D-SNPs and coordinate	Yes	21,702	
MA	Yes	Senior Care Options (SCO)	Full integration	Yes	21,785	No requirement. However, all current participating plans are also in SCO.
MN	No	MN Senior Care Plus (MSC+)	Medicare not included, but Medicaid contractors expected to coordinate; all MSC+ plans participate in MSHO	Yes	11,995	Yes. Amended MSHO contracts to include terms of administrative demonstration.
		MN Senior Health Options (MSHO)	Full integration	Yes	36,128	
NY	Yes	Medicaid Advantage (MA) and Medicaid Advantage Plus (MAP)	Full integration	In MAP only	9,203 (MA) 2,956 (MAP)	Plans were required to be approved as MLTC plans by 2013. Some plans did not have operational MLTC plans when they applied for demonstration.
		Managed Long Term Care (MLTC)	Medicare not included, but Medicaid contractors expected to coordinate	Yes	45,417	
TX	Yes	STAR+PLUS	Medicaid contractors must have D-SNPs and coordinate	Yes	400,790[f]	Yes. Limited to STAR+PLUS plans.
States in which there <u>is no</u> experience with dually eligible beneficiaries in Medicaid managed care						
IL	No	Integrated Care Program (ICP)	No dually eligible beneficiaries	Yes	36,079	No requirement. However, both existing ICP plans are also in the demonstration, and all demonstration plans became part of ICP expansion.
MI	Yes	Managed Specialty Support & Services Program (MSS&S)	Dually eligible beneficiaries included, but no integration	Yes	41,272	
OH	Yes	(None)				
SC	Yes	(None)				
VA	Yes	(None)				

Sources:
Saucier P, Kasten J, Burwell B, and Gold L, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Health Analytics. Prepared for CMS. 2012. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf
National Association of States United on Aging and Disability (NASUAD), "State Medicaid Integration Tracker." January 1, 2015. http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker
States' MOUs with CMS and state procurement documents.

Notes:
[a] All states with PACE had only small numbers of dually eligible beneficiaries enrolled, up to 1 percent.
[b] Full integration means that contractors receive both Medicaid and Medicare capitation rates, and beneficiaries enroll in the same plan to receive both Medicare and Medicaid benefits (Saucier et al. 2012). The four state programs that fully integrate Medicare/Medicaid all now operate as FIDE SNPs (see "CMS SNP Comprehensive Report"). Other types of integration are as noted in Saucier et al. 2012.
[c] From P. Saucier et al., California CalOptima and HPSM data from "CMS SNP Comprehensive Report," March 2012. Illinois data as of February 2013, from Integrated Care Program website. https://www2.illinois.gov/HFS/PUBLICINVOLVEMENT/INTEGRATEDCAREPROGRAM/Pages/default.asp; New York MA and MAP data from New York's "Medicaid Managed Care Enrollment Reports," December 2012. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/
[d] California also is rolling out MLTSS within its Medicaid plans, concurrent with the financial alignment demonstration. See "DHCS Updates the CCI's Timeline." March 2014. http://www.calduals.org/2014/03/25/dhcs-updates-the-ccis-timeline/
[e] The six County Organized Health System (COHS) plans in California manage custodial care in nursing facilities (described on page 56 of California's demonstration proposal). Two of them, CalOptima and Health Plan of San Mateo, also have long-term experience with both MMC plans and D-SNPs; in 2006, they both had passive enrollment of dually eligible beneficiaries into their D-SNP product lines from their MMC plans. Enrollment numbers in the table reflect total D-SNP enrollment for these two plans in March 2014.
[f] About 214,000 of STAR+PLUS enrollees were fully dually eligible, and about 43,000 of them also were enrolled in a SNP. Of the 43,000, about 17,000 were enrolled in the same health plan for both Medicaid and SNP (Texas Application for the Dual Eligibles Integrated Care Demonstration Project, 2012. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf)

States with Full Integration Programs

Four demonstration states had programs that included full integration and MLTSS before launching their demonstrations (California, Massachusetts, Minnesota, and New York). Full integration contractors receive both Medicaid and Medicare capitation rates, and beneficiaries enroll in the same plan to receive both Medicare and Medicaid benefits.[31] These four states represent four of the five states nationwide that had programs with both MLTSS and full integration as of 2012.[32] While these four states have more experience in care integration than most other states nationwide, the scope of their programs and size of enrollment differs, with Massachusetts and Minnesota having substantially larger integrated programs than California and New York.

- Massachusetts's longstanding program, Senior Care Options, enrolls Medicaid beneficiaries ages 65 and older, including dually eligible beneficiaries. (The state's demonstration focuses on adults under age 65, who may have different service needs, such as greater needs for behavioral health care).
- Minnesota's fully integrated program (Minnesota Senior Health Options) has essentially been converted into the state's administrative alignment demonstration.
- New York had small programs for integrating care for dually eligible beneficiaries (Medicaid Advantage and Medicaid Advantage Plus) and a larger program for Medicaid MLTSS (Managed Long Term Care), which it has been expanding.
- California has SCAN Connections at Home, which originated as a social HMO but later became a FIDE SNP that operates through a single health plan (SCAN) in a limited geographic area.[33] California is not employing the Medicare Advantage model used by SCAN in the demonstration or including SCAN as a demonstration health plan. Instead, it is building on its large MMC program by contracting with its existing Medicaid health plans, which served dually eligible beneficiaries before the demonstration. Concurrent with its demonstration roll-out, California also is placing MLTSS services under its Medicaid health plans.

States with Other Integration Programs

A few additional demonstration states had programs that partially integrated care for dually eligible beneficiaries by having the same contractors for both Medicaid and D-SNP, and coordination between the two. In the Texas STAR+PLUS program, health plans are required to have both MMC and D-SNP contracts in the most populous counties in their service areas, and to coordinate between the two. In California Medicaid's County Organized Health Systems (COHS), MMC contractors cover nursing facility services, and two of the COHS plans have D-SNP experience dating back to 2006. These two plans (CalOptima and Health Plan of San Mateo) have coordinated MMC and D-SNP services for many enrollees, especially since their MMC enrollees were passively enrolled into their D-SNPs in 2006 (and therefore they had many of the same beneficiaries enrolled in both their Medicaid and D-SNP plans). CalOptima and Health Plan of San Mateo are both participating in California's demonstration, although CalOptima's demonstration plan enrollment has been delayed until later in 2015.

Other Demonstration States

All five of the states with no previous enrollment of dually eligible beneficiaries in capitated MMC were less advanced in their efforts to integrate care and/or manage LTSS – both key components of the demonstrations. The Illinois Integrated Care Program for Medicaid-only enrollees who are elderly, blind, or disabled began

including MLTSS in 2013. Michigan Medicaid has a program with MLTSS for those with developmental and intellectual disabilities and serious mental illnesses, but it does not integrate care for enrollees who are also eligible for Medicare. The remaining three states had no prior integrated programs for dually eligible beneficiaries and no MLTSS (Ohio, South Carolina, and Virginia). However, some states (such as Illinois and South Carolina) are also implementing other, broader shifts toward capitated MMC, and the demonstration is providing a vehicle to do so for dually eligible individuals.

Health Plan Selection for Demonstrations

Some states allowed only organizations that already operated particular in-state health plans to participate in the demonstrations, whereas others opened demonstration participation to a much broader set of health plans (see Table 4). Not surprisingly, this distinction largely follows the level of related experience within states and among their health plans.

Most states with existing integration programs and dually eligible beneficiaries in MMC decided to limit demonstrations to health plans with at least some experience in related in-state programs. Four of the demonstration states directly linked their demonstration health plan selection to plans participating in other relevant state Medicaid programs (California, Minnesota, New York, and Texas). Whereas Texas and Minnesota are building from plans already participating in integrated programs (STAR+PLUS and Minnesota Senior Health Options, respectively), California and New York are drawing from health plans under contract with MMC generally. In California, Medicaid generally, and the demonstration specifically, have models that vary by county. One of these models – the two-plan model involving a public and private plan – required adaptation in Los Angeles after one of the two plans (L.A. Care) had low Medicare quality scores, making it ineligible to accept passively enrolled individuals. Thus, three additional plans were added in Los Angeles County: Anthem's CareMore (a specialized unit with an active D-SNP in the county), Molina (with extensive Medicaid enrollment elsewhere in California and the nation), and Care1st (a provider-led organization with Medicare Advantage plans and a D-SNP in the county, a contract with L.A. Care, and a Medicaid plan in neighboring San Diego county).[34] In New York, the demonstration was limited to plans that were certified for the state's Managed Long Term Care program, though some demonstration health plans did not yet have operational MLTC plans when they applied for the demonstration in 2013.

In contrast, other states had procurements that allowed health plans with varying backgrounds to apply for the demonstrations. These states generally asked those health plans applying about their relevant experience (such as with Medicare, Medicaid, and dually eligible beneficiaries), and in some cases set some broad thresholds (for example, Ohio required that plans have an existing Medicare Advantage contract somewhere in the country). However, the states with broader procurements did not limit demonstration participation to particular existing in-state Medicaid health plans. In some cases, these states nonetheless are working with health plans that have previous in-state enrollment in Medicare, Medicaid, or MLTSS programs—even though a state had not set such enrollment as a threshold. The similar past experience of these health plans may have made states view them more favorably or the plans themselves may have been more interested than other plans in participating in the demonstration.

Health Plan Background and Experience

Whereas the states and CMS structure the policies, procedures, and monitoring of the Initiative, much of the day-to-day work ultimately depends on health plan actions and competency (for example, via provider network development and the manner in which they promote quality and coordinate care). Because the demonstration health plans are melding the detailed requirements of both Medicare and Medicaid, and addressing the complex needs of dually eligible beneficiaries, their past experience is important, both in considering their regulatory experience and their familiarity with serving dually eligible beneficiaries.

Our analysis of health plans focuses on those in the five states that had enrolled beneficiaries in capitated financial alignment demonstrations by December 2014 (California, Illinois, Massachusetts, Ohio, and Virginia). A total of 29 health plans from 24 firms are participating in the demonstrations in those states; details on their prior experience and the quality ratings of plans operated by the same organizations are discussed in this section. Although additional states are opening enrollment in 2015, their health plans are not included here in detail, as the set of participating health plans may evolve during the launch of the demonstration (as it has in some other states). Brief information on health plans in these states also is provided in this section. Health plans in Minnesota's administrative alignment demonstration also are not reviewed here in detail, as this demonstration adds only some administrative alignment functions to existing integrated contractors (which all had existing FIDE SNP and Medicaid contracts).

Experience of Participating Health Plans in Demonstration States Operational in 2014

Table 5 summarizes the key characteristics of the 29 health plans participating in the demonstration, including the prior experience they or their affiliated companies (those under the same parent company) have had in serving Medicare, Medicaid, or dual eligible enrollees within the state, as well as Medicare or Medicaid enrollees out of state. A few of the organizations operating demonstration health plans (Centene, Humana, Molina, and Anthem) have plans in more than one of these five states. These four companies accounted for 9 of the 29 plans in the demonstration. Ten of the health plans were local and had no Medicare or Medicaid enrollment out of state. The landscape of health plans varies by state, with Massachusetts and California including many local plans – all of which also have familiarity with dually eligible beneficiaries in MMC – and Illinois, Ohio, and Virginia including mainly national, for-profit plans.

Table 5. Selected Organizational Characteristics and Prior Experience of Capitated Demonstration Health Plans, by State									
			Prior Medicare Advantage (MA) Enrollment in State (2014)[a]			Prior Medicaid Managed Care (MMC) Enrollment in State		Out-of-State Experience	
State	Demonstration Health Plan (Parent Organization, when Different)[a]	Tax Status[a]	Non-SNP MA Enrollment	Dual SNP Enrollment	Other SNP Enrollment[d]	Enrollment (2012)[b]	Dual Eligibles in Medicaid Health Plan (2011)[c]	MA	MMC
CA	Anthem Blue Cross, including CareMore	For Profit	72,951	1,141	**20,289**	448,492	Yes	Yes	Yes
	CalOptima (Orange County Health Authority)[e, f]	Nonprofit	0	**16,014**	0	376,053	Yes	No	No
	Care1st Health Plan	For Profit	22,584	13,545	0	28,625	Yes	Yes	Yes
	Community Health Group	Nonprofit	0	1,216	0	122,225	Yes	No	No
	Health Net	For Profit	**116,471**	**33,284**	**3,972**	**719,907**	Yes	Yes	Yes
	Health Plan of San Mateo	Nonprofit	0	8,747	0	59,983	Yes	No	No
	IEHP DualChoice (Inland Empire Health Plan)	Nonprofit	0	11,559	0	**501,503**	Yes	No	No
	L.A. Care (Local Initiative Health Authority for L.A. County)	Nonprofit	0	6,994	0	**997,719**	Yes	No	No
	Molina Healthcare of California	For Profit	0	8,498	0	201,440	Yes	Yes	Yes
	Santa Clara Family Health Plan (Santa Clara County Health Authority)	Nonprofit	0	0	0	116,644	Yes	No	No
IL	Aetna Better Health	For Profit	**42,144**	0	0	**18,000**[g]	No	Yes	Yes
	BlueCross BlueShield of Illinois (Health Care Service Corp.)	Nonprofit	5,801	0	0	0[g]	--	Yes	Yes
	Cigna-HealthSpring CarePlan of Illinois	For Profit	12,223	**3,385**	0	0[g]	--	Yes	Yes
	Health Alliance Connect	For Profit	12,570	0	0	0[g]	--	Yes	No
	Humana Health Plan, Inc.	For Profit	**84,077**	21	**280**	0[g]	--	Yes	Yes
	IlliniCare Health (Centene)	For Profit	0	0	0	17,800[g]	No	Yes	Yes
	Meridian Complete (Caidan Enterprises)	For Profit	86	81	0	7,300[g]	No	Yes	Yes
	Molina Healthcare of Illinois	For Profit	0	0	0	0[g]	--	Yes	Yes

Table 5. *(continued)*									
			Prior Medicare Advantage (MA) Enrollment in State (2014)[a]			Prior Medicaid Managed Care (MMC) Enrollment in State		Out-of-State Experience	
State	Demonstration Health Plan (Parent Organization, when Different)[a]	Tax Status[a]	Non-SNP MA Enrollment	Dual SNP Enrollment	Other SNP Enrollment[d]	Enrollment (2012)[b]	Dual Eligibles in Medicaid Health Plan (2011)[c]	MA	MMC
MA	Commonwealth Care Alliance, Inc.	Nonprofit	0	**5,357**	0	4,236	Yes	No	No
	Fallon Total Care or Fallon Health[f]	Nonprofit	13,192	3,685	0	14,212	Yes	No	No
	Tufts Health Plan — Network Health	Nonprofit	**105,215**	199	0	**124,174**	Yes	No	No
OH	Aetna Better Health	For Profit	**156,428**	0	0	0	--	Yes	Yes
	Buckeye Health Plan (Centene)	For Profit	0	**1,284**	0	**168,143**	No	Yes	Yes
	CareSource	Nonprofit	0	**1,076**	0	**920,940**	No	No	Yes
	Molina Healthcare of Ohio	For Profit	0	517	0	**262,932**	No	Yes	Yes
	UnitedHealthcare Community Plan	For Profit	75,267	**8,306**	**4,256**	122,630	No	Yes	Yes
VA	Anthem HealthKeepers	For Profit	4,167	0	**584**	**220,835**	No	Yes	Yes
	Humana Health Plan, Inc.	For Profit	**120,184**	**1,529**	**777**	0	--	Yes	Yes
	Virginia Premier CompleteCare (Virginia Commonwealth U. Health System Authority)	Nonprofit	0	0	0	**151,566**	No	No	No

Sources:

[a] Analysis of CMS Medicare Advantage enrollment and Landscape files, 2014.

[b] CMS. "2012 Medicaid Managed Care Enrollment Report." http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf

[c] CMS. "2011 Medicaid Managed Care Enrollment Report." http://www.medicaid.gov/medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf

Notes: Table includes states with active enrollment in capitated financial alignment demonstrations as of December 2014. All health plan enrollment noted reflects that of in-state health plans operated by the same parent organization as the demonstration health plan. Previous Medicaid MMC enrollment reflects MCO and HIO enrollment only.

Numbers in bold reflect the three largest health plans statewide in a given state's product line (Medicare Advantage, D-SNP, other SNP, or MMC).

[d] "Other SNP" experience reflects chronic condition SNP enrollment. The exceptions: part of Anthem's (CA) enrollment and all of UnitedHealthcare's (OH) enrollment is in institutional SNPs.

[e] CalOptima's D-SNP plan was sanctioned by CMS in January 2014 and CalOptima thus was not eligible for demonstration enrollment. As of November 2014, CalOptima's D-SNP was again open for enrollment, though enrollment in its demonstration plan will begin no sooner than July 2015. http://www.calduals.org/2014/11/14/alameda-orange-county-updates /

[f] Two health plans also have PACE plans with small numbers of enrollees – Fallon (MA) and CalOptima (CA).

[g] In 2012, Aetna Better Health and IlliniCare were the only contractors for Illinois's Integrated Care Program (ICP) (for elderly, blind, and disabled Medicaid-only enrollees). In its 2013 and 2014 expansion of ICP, Illinois also contracted with all of the financial alignment demonstration health plans as Medicaid-only plans for ICP. As of October 2014, each of the Illinois demonstration plans also had a few thousand Medicaid enrollees each in ICP. Illinois "Enrollment for Integrated Care Program (ICP)." http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ICPEnrollment.aspx)

Of the two states with previous enrollment of dually eligible beneficiaries in capitated MMC:

- **California** is including 10 health plans in its demonstration, with a heavy base of local nonprofit plans, along with some for-profit plans with strong ties to the state. As discussed above, California allowed only its existing Medicaid plans in the demonstration counties to participate; thus, all plans have significant Medicaid enrollment. It is important to note that California previously did not generally include LTSS under its health plans (except in the COHS plans);[35] the Medicaid plans' experience with dually eligible beneficiaries thus was mostly with the minimal other services covered by Medicaid for dually eligible beneficiaries. California is phasing in MLTSS under its Medicaid health plans concurrent with the demonstration. All health plans except for one (Santa Clara Family Health Plan) also have D-SNP enrollment; three also have general Medicare Advantage product lines.
- **Massachusetts's** demonstration includes three local nonprofit plans that all participate in its integrated Senior Care Options (SCO) program. These plans have experience with Medicare/Medicaid integration, though the care needs of those in the demonstration (dually eligible beneficiaries who are under 65 and disabled) differ from the needs of those in SCO (elderly dually eligible beneficiaries). Though Massachusetts initially selected three additional health plans (which do not participate in SCO and are for-profit) for its demonstration, these plans withdrew, mainly citing concerns about the demonstration's payment rates. This development left the three nonprofit health plans that have more specialized experience with dually eligible beneficiaries.[36] One participating firm also has a large Medicare Advantage line.

Of the three states with no previous enrollment of dually eligible beneficiaries in capitated MMC:

- **Illinois's** demonstration includes eight health plans. Most plans in Illinois did not have in-state Medicaid enrollment when they first contracted for the demonstration. In general, the state had very low risk-based MMC penetration. Health plans related to two of the demonstration plans (Aetna and IlliniCare/Centene) were the contractors for the state Medicaid's ICP, which began in 2011 for Medicaid-only beneficiaries who are elderly or disabled. However, as Illinois moved rapidly toward risk-based MMC and the recently expanded ICP, it contracted with all of its demonstration health plans for this expansion, which began slightly before the demonstration. These plans thus are developing in-state Medicaid experience at the same time as they begin the demonstration. Six of the health plans have at least some in-state Medicare experience, including two plans that are among the largest Medicare plans in the state.
- **Ohio** is including five health plans in its demonstration; four of these have a large Medicaid presence in the state as well as D-SNPs. An additional health plan related to one of the state's largest Medicare plans (Aetna) also is participating, though it does not have any in-state Medicaid enrollment.
- **Virginia's** demonstration includes three health plans, two of which are related to Medicaid plans that are among the largest in the state. One of the plans (Anthem) has a small number of Medicare enrollees in the state, while the other (Virginia Premier) is a local Medicaid plan with no Medicare experience. The third plan (Humana) operates one of Virginia's largest in-state Medicare plans, though has no previous in-state Medicaid enrollment.

Almost all of the organizations operating health plans across these states have at least some in-state Medicare Advantage enrollment, though not necessarily enrollment in D-SNPs. The few organizations with no in-state Medicare experience are either local, state Medicaid-focused plans (Santa Clara Family Health Plan in

California and Virginia Premier in Virginia) or national health plans with Medicare experience in other states (IlliniCare/Centene and Molina in Illinois). About one-third of the organizations have in-state enrollment in both regular Medicare Advantage and D-SNPs. The type of Medicare plans of organizations operating health plans varies by state in some cases; almost all of California's plans have D-SNPs, whereas plans in Illinois primarily had regular Medicare Advantage. (As shown in Table 3, Illinois has very limited D-SNP enrollment.) A handful of organizations also have some enrollees in other SNP types (for people with chronic conditions or requiring an institutional level of care).

Almost all organizations also have significant in-state Medicaid experience that predated the demonstrations. The main exception is in Illinois – most organizations operating health plans in Illinois did not have such experience when they first contracted with the state. Only two other organizations across the other states had no in-state Medicaid enrollment, though those plans have large in-state Medicare Advantage market shares (Humana has 63% in Virginia and Aetna has 20% in Ohio);[37] instead, they are building on significant local experience in Medicare.

Experience of Participating Health Plans in Demonstration States Beginning in 2015

Table 6 displays high-level information on the previous in-state experience of organizations operating health plans expected to be in the demonstration states that begin enrollment in 2015. As discussed above, these health plans are not discussed here in detail, as the specific participating health plans may still change.

In general, these states are contracting with national for-profit plans with the exception of New York, which is including many local nonprofit, provider-based health plans already in its MLTC program. New York and Texas both are building on existing in-state health plans for their demonstrations, but these plans' backgrounds vary widely. All Texas plans have previous in-state Medicare (including D-SNP) and Medicaid enrollment. However, New York's plans all have Medicaid experience (some of them only in MLTSS), but about one-third have no prior Medicare experience. Though New York's plans have specialized experience in MLTSS, and some have it in integrated care (via Medicaid Advantage Plus), the lack of Medicare experience indicates that some will have a steep learning curve in that area. As for other 2015 states, health plans in Michigan and South Carolina have a range of backgrounds, with some lacking previous in-state Medicare and/or Medicaid enrollment (especially in South Carolina).

Table 6. Prior Experience of Capitated Demonstration Health Plans in Demonstration States Planned to Begin Operations in 2015, by State		
State	**Health Plans[a]**	**Health Plans' Prior In-State Experience[b]**
Michigan	AmeriHealth, CoventryCares, Fidelis SecureCare, Meridian Health Plan, Midwest Health Plan, Molina, Upper Peninsula Health Plan	Five have Medicare and Medicaid experience, one has only Medicare, and one has neither.
New York	Based on Managed Long Term Care plans: Aetna Better Health of New York, AgeWell, AlphaCare, Amerigroup, Archcare Community Life, Centerlight Healthcare, Centers Plan for Healthy Living, Elderplan, Elderserve Health, Fidelis Care of NY (NYS Catholic Health Plan), GuildNet, Managed Health (HealthFirst), Health Insurance Plan of Greater New York (HIP), Independence Care Systems, Integra, MetroPlus, Montefiore HMO, North Shore-LIJ Health System, Senior Whole Health, VillageCareMAX, VNS Choice, Wellcare	All have MLTC experience, and some have other Medicaid experience (including eight that also have Medicaid Advantage Plus plans – see Table 4). Fifteen plans also have Medicare experience and seven plans do not.
South Carolina	Absolute Total Care (Centene), Advicare, Molina, Select Health of South Carolina (AmeriHealth)	One has only Medicaid experience, one has only Medicare, and two have neither.
Texas	Based on STAR+PLUS health plans: Amerigroup, Cigna-Healthspring, Molina, Superior (Centene), UnitedHealthcare	All have prior Medicare and Medicaid plans.

Sources:

a Musumeci M, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," Washington DC: Henry J. Kaiser Family Foundation, July 2014. Update on New York: "FIDA Plans by Region." https://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

[b] Analysis of CMS Medicare Advantage enrollment and Landscape files, 2014; CMS. 2012 Medicaid Managed Care Enrollment Report. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf; state and health plan websites.

Notes: Minnesota's administrative demonstration, which modified existing contracts with FIDE SNPs in Minnesota Senior Health Options, includes Blue Plus, HealthPartners, Itasca Medical Care, Medica Health Plans, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, and UCare Minnesota.

Available Information on Quality Ratings of Participating Health Plans

Given the complex needs of the dual eligible population, it is important to understand what is known about the quality of care provided by health plans participating in the demonstration. Quality ratings of the existing related Medicare and Medicaid plans can give insight into the infrastructure and culture that health plans bring to the demonstrations.

Table 7 summarizes data on available quality ratings for the existing in-state Medicare and Medicaid health plans related to demonstration plans, including both the Medicare Advantage star rating for the plan (general Medicare and D-SNP, when available) and Medicaid plan rankings by the National Committee on Quality Assurance (NCQA). The quality scores range from 1 to 5, with 5 being the highest. Medicare Advantage plans with 4 stars or more qualify for additional bonus payments, and NCQA highlights scores of 4 or 5 as being better across three performance categories.[38] Medicare Advantage star ratings are assessed at the contract level, not the health plan level. Thus, unless a company offers only SNPs under its contract, the quality scores will reflect the overall performance of all health plans under a contract, not necessarily the performance of the D-SNP. For this reason, and because the metrics may not account for enrollee characteristics in D-SNPs, many believe that star ratings may unfairly disadvantage D-SNPs.[39] It is also important to note that while LTSS are a key part of the demonstrations, the quality measures that states use for LTSS vary greatly and there is no standardized set of measures that allows for comparison in this brief.[40]

The data show considerable diversity in scores, both across plans and states. Across the states, Massachusetts' demonstration plans have consistently high quality scores, with two of the three plans scoring at the top of the ratings in Medicare and Medicaid, and the third, a specialized plan, scoring highly for its D-SNP offering. In contrast, and not surprising given its limited MMC experience, Illinois plans (with one exception) have no available Medicaid quality ratings. Only four of its contracted plans have Medicare quality ratings for in-state plans, including two with a rating for D-SNPs. (The ratings for these plans vary from 3.5 to 4.5.)

In Ohio and Virginia, all of the plans have ratings, but often just for one program (generally because they do not have a plan to be rated). Ohio's five plans include three with MMC ratings, one of which also has a Medicare rating for D-SNPs, and two with only general Medicare Advantage ratings. Though there is variation by plan and element, these ratings tend to be about average (3 or 3.5), with plans worse on some dimensions (Centene's Buckeye plan rated 2 on Medicaid prevention, CareSource's 2.5 on D-SNP) and higher on others (CareSource with a 4 for consumer satisfaction and Molina with a 4 for treatment). In Virginia, two of the three plan ratings were average on two dimensions, but had a 4 for quality of treatment. The third, a Humana plan, did not have a Medicaid plan in the state and had average Medicare ratings (3.5).

Among these states, California stands out because of the relatively large number of plans with low MMC ratings from NCQA. Of the 10 participating plans, 8 had reported scores. Almost all have the lowest rating for consumer satisfaction (1); a few have below average ratings (1 or 2) for prevention or treatment. The D-SNP of the best performing Medicaid plan (CalOptima, a COHS health plan in Orange County) was sanctioned by CMS in January 2014 due to "widespread and systemic failures" that impacted its D-SNP enrollees' access to care; for this reason, demonstration enrollment in that county has been delayed until at least July 2015.[41] However, the D-SNP scores for California plans are better (mostly 3 and 3.5) than their Medicaid scores.

Table 7. Quality Ratings of In-State Health Plans Related to Demonstration Health Plans, by State								
		Medicare[a, c]		Medicaid – NCQA[b, d]				
State	Demonstration Health Plan Name	Medicare Advantage Stars	D-SNP Stars	Overall Score	Consumer Satisfaction	Prevention	Treatment	National Rank
CA	Anthem Blue Cross, including CareMore	4	4	75	1	3	3	106
	CalOptima (Orange County Health Authority)	N/A	3.5	82	1	5	4	29
	Care1st Health Plan	3.5	3.5	76	1	2	3	102
	Community Health Group	N/A	3.5	74	2	2	2	110
	Health Net	4	4	70	1	2	2	119
	Health Plan of San Mateo	N/A	3.5	NR				
	IEHP DualChoice (Inland Empire Health Plan)	N/A	3	73	1	3	2	112
	L.A. Care (Local Initiative Health Authority for L.A. County)	N/A	3	76	3	3	3	99
	Molina Healthcare of California	N/A	3	77	1	3	3	95
	Santa Clara Family Health Plan (Santa Clara County Health Authority)	N/A	N/A	NR				
IL	Aetna Better Health	4	N/A	NR				
	BlueCross BlueShield of Illinois (Health Care Service Corp.)	NR	N/A	N/A				
	Cigna-HealthSpring CarePlan of Illinois	3.5	3.5	N/A				
	Health Alliance Connect	4.5	N/A	N/A				
	Humana Health Plan, Inc.	4	4	N/A				
	IlliniCare Health (Centene)	N/A	N/A	NR				
	Meridian Complete (Caidan Enterprises)	NR	NR	85	4	5	5	10
	Molina Healthcare of Illinois	N/A	N/A	N/A				
MA	Commonwealth Care Alliance, Inc.	N/A	4.5	NR				
	Fallon Total Care or Fallon Health	4.5	4.5	87	5	5	5	2
	Tufts Health Plan – Network Health	4.5	4.5	87	5	5	5	1
OH	Aetna Better Health	3.5	N/A	N/A				
	Buckeye Health Plan (Centene)	N/A	NR	77	3	2	3	98
	CareSource	N/A	2.5	79	4	3	3	66
	Molina Healthcare of Ohio	N/A	NR	79	3	3	4	82
	UnitedHealthcare Community Plan	3.5	3.5	78	3	3	3	90
VA	Anthem HealthKeepers	3.5	N/A	79	3	3	4	73
	Humana Health Plan, Inc.	3.5	3.5	N/A				
	Virginia Premier CompleteCare (Virginia Commonwealth U. Health System Authority)	N/A	N/A	79	3	3	4	62

Key: **1 – 2 (Worse)** 3 (Average) **4 – 5 (Better)**

Sources:

[a] 2014 Medicare Star Ratings Data.

[b] National Committee on Quality Assurance (NCQA). "Health Insurance Plan Rankings 2014–2015." http://healthplanrankings.ncqa.org/2014/

Notes: Includes states with active enrollment in capitated financial alignment demonstrations as of December 2014. All health plan experience noted reflects that of in-state health plans operated by the same parent organization as the demonstration health plan.

[c] Medicare Advantage stars: out of 5 stars; 5 = excellent; 4 = above average, 3 = average, 2 = below average, 1 = poor. N/A = organization has no in-state health plan. NR = not rated. For any organization with multiple plan ratings in a state (preferred provider organization (PPO) vs. health maintenance organization (HMO)), HMO ratings are shown, due to HMO similarity to the demonstration health plan product line. In cases in which an organization has more than one star-rated HMO in a state (Anthem in CA and Humana in IL), the rating for the larger plan is shown. For more information on the star rating system, see http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

[d] NCQA: 2014—2015. N/A = parent company has no in-state health plan. NR = not ranked. The overall score is out of 100, and the ranking is out of 136 nationally ranked plans. All ranked plans (and IlliniCare) also are NCQA accredited. More information on rankings is available at NCQA, Health Insurance Plan Rankings: Ranking Resources. http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings.aspx

L.A. Care (CA) and CareSource (OH) Medicare plans received a Medicare Low Performing Icon for 2014. CalOptima's D-SNP was sanctioned by CMS in January 2014.

Discussion

Our analysis suggests that many of those engaged in the demonstrations (including states, health plans, and providers) will encounter a substantial learning curve. In some states, such as Massachusetts and Minnesota, the demonstrations are building on previous experience fully integrating care for dually eligible beneficiaries. Others (like California, New York, and Texas) have had some previous experience with integrating care, but on a more limited basis.

In all five of the states with prior enrollment of dually eligible beneficiaries in capitated MMC, the demonstrations are contracting with companies that also operate health plans in their existing Medicaid programs that serve dually eligible beneficiaries and/or include MLTSS (see Table 4). This experience is useful, but by itself does not necessarily translate into high-quality care. Our findings show that across and within states, the quality ratings of care in existing Medicare and Medicaid plans vary considerably. For example, health plans participating in the Massachusetts demonstration all score relatively high on available quality metrics, whereas performance is lower and less consistent in California. Additionally, even in some more experienced states, some health plans have considerable gaps in their experience that is relevant to the demonstration. California's Medicaid health plans generally did not include MLTSS in the past, and many of New York's demonstration health plans have managed Medicaid MLTSS only and lack experience with managing Medicare, or even acute care services under Medicaid.

The other five states implementing capitated financial alignment demonstrations (Illinois, Michigan, Ohio, South Carolina, and Virginia) have much less experience on which to build. They have no previous enrollment of dually eligible beneficiaries in capitated MMC, and generally also have low D-SNP penetration. Even more so than in experienced states, this means that the complexities of developing provider networks, tailoring care management models for dually eligible beneficiaries, and providing integrated care may be more challenging for these states and their health plans. The three of these states that began demonstrations in 2014 (Illinois, Ohio, and Virginia) have generally contracted with health plans with considerable experience in their state in either Medicare or MMC, but not necessarily both. These states, and some others with less experience, are relying mainly on national companies that may be able to bring their Medicare and/or Medicaid knowledge from other states to bear, even though the specifics of the context and environment may be different.

It remains unclear how the financial alignment demonstration will play out. As indicated above, state and health plan experience with related capitated and/or integrated programs is quite variable. Additionally, though many states were interested initially, fewer are actively pursuing demonstrations now. Also, some health plans have lost interest in the demonstration as its details have emerged. Enrollment in demonstrations has been delayed repeatedly, but enrollment reached about 310,000 across financial alignment demonstration states as of January 2015, and further enrollment is expected in 2015.

All of these facts, as well as the complexity of integration and the care needs of dually eligible beneficiaries, make effective federal oversight of the demonstration, when done in ways that complement state activity, very important in assuring beneficiary protections. Because the goal of the demonstrations is to integrate care across the spectrum of needs covered by Medicare and Medicaid, effective oversight must assess not only how well Medicare and Medicaid each work for enrollees, but how well they work together. The Financial Alignment Initiative has the potential to provide valuable lessons on these issues.

Appendix A: Reconciling Differences Between Medicare and Medicaid Requirements in the Demonstration

Unlike Medicare, which is a national program, MMC programs and requirements differ across states, though they are required to meet minimum federal Medicaid standards. Although in concept, participating demonstration health plans are required to meet both state Medicaid and Medicare requirements for managed care, some of these requirements are inconsistent or lead to duplication; the differences thus needed to be reconciled when creating the demonstrations. To identify and begin to address these inconsistencies, on January 25, 2012, CMS released initial guidance for comparing requirements across the programs; it followed up on March 29, 2012 with additional guidance on Medicare selection criteria.[42]

Box 1 summarizes selected areas of inconsistency and how their reconciliation affected the way the demonstration is structured in several key areas, including the following:

- **Plan Choice.** The demonstration allows state Medicaid programs to limit the plans that may participate, though Medicare must approve the participants as well. Plans under a Medicare enrollment or marketing sanction are not eligible, and past performance is considered in determining eligibility for passive enrollment.[43]
- **Plan Payment.** The capitated rates paid to health plans in the demonstration are an integrated Medicare-Medicaid payment that builds on approaches used in each program, but is distinct to the demonstration. Bids and benchmarks, an important feature of Medicare Advantage payments, are not used in the demonstration. Instead, Medicare rates reflect the origins of Medicare enrollees in the program (traditional Medicare, Medicare Advantage) and Medicare's estimate of their baseline costs. In addition, withholds rather than bonuses are the main vehicle for quality rewards to plans. Using administered pricing and assumptions on savings, demonstration rates reflect historical costs in each program and proportionate allocation of savings between Medicare and Medicaid.[44] Demonstration savings assumptions vary by state, based on federal-state negotiations.
- **Enrollment and Time Frame.** Under the demonstration, dually eligible beneficiaries may be passively enrolled in a health plan as long as they are allowed to opt out of such enrollment at any time (effective monthly) and the plan meets Medicare and Medicaid performance standards. (In Medicare, all enrollment in Medicare Advantage is completely voluntary.) Time lines for enrollment vary by state and, at least initially, are not closely linked to the Medicare open enrollment time line.
- **Benefits.** Participating health plans must meet all Medicare and Medicaid benefit requirements, filing an integrated benefit package for federal approval. Demonstration plans are not allowed to charge premiums or cost sharing for Medicare benefits. Medicare rules for Part D benefits apply, with plans required to have an approved formulary consistent with Part D requirements. Medicaid benefits for aged, blind, and disabled beneficiaries, including LTSS, must be provided.
- **Care Management.** The demonstration health plans must have an approved Model of Care, covering topics such as care plans and risk assessments. This requirement is similar to those for Special Needs Plans, but such Models of Care are not required in regular Medicare Advantage. Demonstration plans are also required to have a Medication Therapy Management Program consistent with Medicare Part D.

- **Oversight on Adherence to Program Requirements.** Although the intention is that participating plans meet both Medicare and Medicaid requirements in key programmatic areas — including marketing standards and review, network adequacy, fiscal solvency, quality assurance, consumer protection, and administrative and management — the demonstration is structured in ways that seek to avoid duplication of requirements and address inconsistencies on a flexible basis that is reflected in the MOUs and three-way contracts. Reconciling differences in marketing standards and appeals processes so they reflect the characteristics of the population served by the demonstration (low health literacy, disproportionately lower income, and more vulnerable than the average Medicare beneficiary) posed issues of particular concern.[45] Joint federal and state contract management teams were created in each demonstration state in order to oversee the health plans. Medicare retains authority for oversight of Part D.

Perhaps recognizing the vulnerability of dually eligible beneficiaries and the scope of many state demonstrations, the initiative also has stronger up-front processes to review the adequacy of health plans before demonstrations go live than Medicare Advantage, in which enrollment generally builds gradually, and on a voluntary basis. This up-front process occurs in the demonstrations through readiness reviews conducted jointly by states and CMS, covering topics such as assessment processes, care coordination, systems, and provider credentialing and networks.[46] From a Medicare program perspective, the demonstration allows more flexibility in how Medicare Advantage requirements are interpreted in areas such as marketing materials than does the regular Medicare Advantage program; this helps to facilitate alignment with Medicaid and individual state practices.

In part because of these unique features, and also to facilitate monitoring and reporting, CMS contracts separately for each plan in the demonstration, assigning a separate contract number for the legal entities associated with each demonstration plan – even if the firm already participates in Medicare Advantage. Enrollment is tracked separately and counted as part of the demonstration rather than as part of D-SNP or as a general Medicare Advantage plan.

At least initially, CMS also was flexible in establishing separate time lines for approval of the Medicare component of the demonstration plan. Once health plans are established, however, they are asked to follow time lines more consistent with the overall Medicare Advantage program.[47] CMS posts a complete list of plan requirements, and the documents that underlie them, on its website.[48]

Appendix Table 1. Selected Differences in Medicare Advantage and Medicaid Managed Care Requirements			
Design Issue	**Federal Medicaid Requirements**	**Medicare Advantage Requirements**	**Financial Alignment Demonstration Design**
Plan Selection	States can limit the number of health plans as long as two choices are offered if there is mandatory enrollment. They also can choose the time frame for selecting new plans.	Plans are selected on an annual basis; all that meet specified requirements can participate.	A joint federal-state selection process allows limits on the number of qualified plans. However, previous performance in Medicare and Medicaid is considered in approval.
Plan Payment Rates (Capitation)	Must meet CMS actuarial soundness standards, but states have flexibility on aspects such as methods and use of risk corridors.	Plans submit separate bids for Part C (A and B benefits) and Part D (pharmacy benefits) that are reviewed against federal benchmarks by county, using standardized rules and risk adjustments.	Reflects government estimates of baseline spending in both programs and assumptions on anticipated savings, which are shared proportionally across Medicare and Medicaid.
Quality Incentives	At state option.	MA has quality "star" bonuses.	No star bonuses but, at state option, plans can earn back withholds if they meet quality objectives. (All states so far have this feature.)
Enrollment	Voluntary or mandatory with CMS approval and at least one opportunity to change annually.	Voluntary, with lock-in through the year, but dually eligible beneficiaries can change monthly, with limited exceptions. New dually eligible beneficiaries may be enrolled into zero-premium Part D plans randomly (although they may change plans).	CMS, at state request, can approve passive enrollment with advance notice to beneficiary and option for "opt out" at any time (effective the first day of the following month).
Enrollment Effective Date	No federal requirements, so it varies by state. (States with lock-in must allow at least an annual change.)	January 1 contract year starts with an open enrollment period from October 15—December 7. Dually eligible beneficiaries can change plans monthly, effective the first of the following month. A Medicare website helps beneficiaries identify the available plans and plan characteristics.	The start dates for demonstrations are negotiated individually with each state. As the demonstration goes forward, CMS plans to review existing demonstration plans against Medicare standards annually (effective for the 2015 plan solicitation).
Model of Care Requirements	None, though state contracts need to address primary care source, coordination, and (for special needs individuals) assessment and treatment.	Required of Special Needs Plans (regular Medicare Advantage Plans are required only to coordinate care). Part D plans are required to have medication therapy management programs.	Model of care requirements apply. Plans also must have an approved Medication Therapy Management Program consistent with Part D.

Appendix Table 1. *(continued)*			
Design Issue	**Federal Medicaid Requirements**	**Medicare Advantage Requirements**	**Financial Alignment Demonstration Design**
Oversight of Access, Quality, Program Integrity, and Financial Solvency	Individual states set requirements consistent with minimum federal standards for Medicaid.	Medicare Advantage has uniform national requirements and an integrated oversight structure for the program.	Oversight is consistent with the MOU but the three-way contract is the explicit statement of requirements that supplants it. The intent is that oversight be at least as rigorous as under Medicare Advantage, Part D, and relevant state programs. Medicare retains authority for oversight of Part D. CMS documents provide that a joint federal-state management team oversee the demonstrations.

Sources:

Medicare and Medicaid requirements are the authors' summary of analysis in Appendix 1 of CMS comparison of Medicare and Medicaid requirements (January 25, 2012). The last column reflects how these requirements ultimately were addressed as reflected in the March 29, 2012 CMS memorandum, review of three-way contract requirements, and authors' knowledge of Medicare Advantage requirements.

Endnotes

[1] Young K, Garfield R, Musumeci M, Clemans-Cope L, and Lawton E, "Medicaid's Role for Dual-Eligible Beneficiaries." Washington, DC: Henry J. Kaiser Family Foundation, August 2013. http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/; Jacobson G, Neuman P, and Damico A, "Medicare's Role for Dual Eligible Beneficiaries." Washington, DC: Henry J. Kaiser Family Foundation, April 2012. http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/

[2] Ibid., and also Neuman P, Lyons B, Rentas J, and Rowland D, "Dx for a Careful Approach to Moving Dual-Eligible Beneficiaries into Managed Care Plans." *Health Affairs*, 31, no.6 (2012):1186—1194.

[3] Before Medicare was expanded through Part D (Prescription Drugs) in 2006 as a result of the Medicare Modernization Act of 2003, Medicaid also provided primary coverage for most prescription drugs.

[4] For more information on Medicare and Medicaid options for dually eligible beneficiaries, see Medicaid and CHIP Payment and Access Commission, "Chapter 3: The Role of Medicare and Medicaid for a Diverse Dual Eligible Population" in *Report to Congress*, Washington DC: March 2013. http://www.macpac.gov/reports

[5] Gold M, Jacobson G, and Garfield R, "There Is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles." *Health Affairs*, 31, no.6 (2012):1176—1185.

[6] For additional detail on MMC options historically, see Medicaid and CHIP Payment Advisory Commission, "Report to Congress: The Evolution of Managed Care in Medicaid." Washington DC: June 2011. http://www.macpac.gov/reports

[7] For more information on Medicare and Medicaid options for dually eligible beneficiaries, see Medicaid and CHIP Payment and Access Commission, "Chapter 3: The Role of Medicare and Medicaid for a Diverse Dual Eligible Population" in *Report to Congress*, Washington DC: March 2013. http://www.macpac.gov/reports

[8] Historically, health plans participating in Medicare managed care programs had to have a strong commercial presence in the market (the so called "50/50 rule," initially designed as a quality enhancement feature). Although this requirement has been absent for some time, participants still tend to include firms with substantial commercial enrollment, particularly in group accounts. Medicaid health plans, in contrast, are more likely to specialize in the Medicaid line of business. Typically they have had experience in working with states and negotiating contracts with providers familiar with the usually lower payment rates offered by Medicaid versus Medicare as well as the special challenges of caring for those enrolled in Medicaid. Safety net and other so called "essential providers" tend to be more prominent in Medicaid health plan networks. Even though such differences are eroding over time as more commercial health plans enter the Medicaid market, Medicaid health plans still remain a separate "line of business" in such companies; whereas there may be more cross-fertilization across the different lines of business, historically this has been limited.

[9] "About the Office of Medicare and Medicaid Coordination." http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html

[10] For additional details on the rationale for this program, see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[11] CMS, State Medicaid Director Letter #11-008. "Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." July 2011. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/financial_models_supporting_integrated_care_smd.pdf

[12] For example, see Kaiser Commission on Medicaid and the Uninsured, "Financial Alignment Models for Dual Eligibles: An Update." November 2011. http://kff.org/health-reform/issue-brief/financial-alignment-models-for-dual-eligibles-an/; Kaiser Commission on Medicaid and the Uninsured. "An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees." April 2012. http://kff.org/medicaid/issue-brief/an-update-on-cmss-capitated-financial-alignment/

[13] National Association of States United on Aging and Disability (NASUAD), "State Medicaid Integration Tracker." January 1, 2015. http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker

[14] Alternatively, the demonstration could have been based around Medicare Advantage requirements, perhaps building on existing programs for Special Needs Plans serving dually eligible beneficiaries. Both options require that Medicare and Medicaid requirements be aligned. However, the state-based focus gives more attention to state interests in long-term care, which accounts for most state spending for dually eligible beneficiaries.

[15] Crowley J, Musumeci M, and Reaves E, "Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders." Washington DC: Henry J. Kaiser Family Foundation, July 2013. http://kff.org/medicaid/issue-brief/development-of-the-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-perspectives-from-national-and-state-disability-stakeholders/

[16] Gold M, Wang W, and Jacobson G, "Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market." Washington DC: Henry J. Kaiser Family Foundation, May 2013. http://kff.org/medicare/report/medicare-health-plans-and-dually-eligible-beneficiaries-industry-perspectives-on-the-current-and-future-market/

[17] This applies to demonstration plans under the same parent company as those with sanctions or low past performance. See CMS "Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013." March 2012. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf

[18] Washington, which has had a managed fee-for-service financial alignment demonstration in most of the state since 2013, also had an MOU with CMS for a capitated financial alignment demonstration in two of its counties. After facing withdrawals by some of its health plans, the state decided in February 2015 not to proceed with a capitated demonstration (See: Washington State Healthcare Authority. "HealthPath Washington Capitated Model Cancelled," February 2, 2015. http://www.hca.wa.gov/medicaid/Documents/HealthPathWALetter.pdf). Regarding earlier issues related to Washington's health plans, see "Regence Faulted for HealthPath Launch Delay," Business Examiner, September 18, 2014. http://www.businessexaminer.com/blog/September-2014/Regence-faulted-for-HealthPath-launch-delay/

[19] For Medicare, see Gold M, Jacobson G, Damico A, and Neuman T, "Medicare Advantage 2014 Spotlight: Enrollment Market Update." Washington DC: Henry J. Kaiser Family Foundation, May 2014. http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-enrollment-market-update/; for Medicaid, see Howell E, Palmer A, and Adams F, "Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future," The Urban Institute, July 2012. http://www.urban.org/UploadedPDF/412617-Medicaid-and-CHIP-Risk-Based-Managed-Care-in-20-States.pdf

[20] Gorn D, "What's Behind High Opt-Out Rate Among Dual Eligibles in L.A. County?" *California Healthline*, December 4, 2014. http://www.californiahealthline.org/insight/2014/whats-behind-high-optout-rate-among-duals-in-los-angeles-county

[21] Minnesota initially submitted a proposal for a capitated financial alignment demonstration. However, it decided not to pursue financial alignment, noting that the demonstration "would result in a significantly lower payment than Minnesota is now receiving for senior Medicare beneficiaries in current programs." Minnesota Department of Human Services website, Update on Status of the Dual Demo, June 29, 2012. http://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=141378

[22] Gold M, Jacobson G, and Garfield R, "There Is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles." *Health Affairs*, 31, no.6 (2012):1176–1185.

[23] The four demonstration states with operating FIDE SNPs represent four of the six states nationwide with such experience as of 2014. (The other two states are Arizona and Wisconsin.)

[24] Gold M, et al. 2012.

[25] Gold M, et al. 2012.

[26] See Exhibit 11 of MedPAC and MACPAC, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." January 2015.

[27] Gold M and Casillas G, "What Do We Know about Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?" Washington DC: Kaiser Family Foundation, November 2014. http://files.kff.org/attachment/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program-report

[28] Denominator includes full and partial dually eligible beneficiaries. Gold M, Jacobson G, Damico A, and Neuman T, "Medicare Advantage 2014 Spotlight: Enrollment Market Update." Washington DC: Henry J. Kaiser Family Foundation, May 2014. http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-enrollment-market-update/

[29] CMS, "Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs." May 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

[30] PACE is a fully integrated program that covers all Medicare services and a state's Medicaid services. It is an option within Medicare in which state Medicaid programs can participate. To be eligible, a beneficiary must live in a PACE plan's service area, be age 55 or older, require a nursing home level of care, and be able to live safely in the community.

[31] Saucier P, Kasten J, Burwell B, and Gold L, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Health Analytics. Prepared for CMS, 2012. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

[32] Saucier P, et al. 2012.

[33] For additional information on SCAN, see its application to participate in San Bernadino County under the demonstration. http://www.dhcs.ca.gov/provgovpart/Documents/Duals/RFS%20Applications/SCAN%20San%20bernardino.pdf .

[34] California Department of Health Care Services, "Enrollment Strategy for Los Angeles County into Cal Medi-Connect Updated." February 18, 2014. http://www.calduals.org/wp-content/uploads/2014/02/REVISED-LA-Enrollment-Strategy-2.19.14-2.0.pdf Additionally, note that Blue Shield of California proposed in December 2014 to acquire Care1st Health Plan. See "Blue Shield of California To Enter Medi-Cal/Medicaid with Acquisition of Care1st." December 8, 2014. https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/care1st-acquisition-agreement-120814.sp

[35] See pages 55—56 of California's "Proposal to the Center for Medicare and Medicaid Innovation -- Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Beneficiaries." May 31, 2012. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAProposal.pdf

[36] Gutman J, "Three of Six Selected Plans Drop Out of Mass. Duals Demo After Pay Rates Finalized." Medicare Advantage News, July 15, 2013. http://aishealth.com/archive/nman072513-01

[37] See appendices of Gold M, Jacobson G, Damico A, and Neuman T, "Medicare Advantage 2014 Spotlight: Enrollment Market Update." Washington DC: Henry J. Kaiser Family Foundation, May 2014. http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-enrollment-market-update/

[38] 4 and 5 correspond to being in the top one-third or top 10 percent of all health plans evaluated by NCQA. Methodology available at NCQA, "Health Insurance Plan Rankings 2014—2015 Methodology Overview." July 2014. http://www.ncqa.org/Portals/0/Health%20Plan%20Rankings/2014/HPR2014_RankingsMethodologyOverview_Final_Update_7.30.14%20(1).pdf

[39] CMS, "Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees." http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf; Weiss H, and Pescatello S, "Medicare Advantage: Stars System's Disproportionate Impact on MA Plans Focusing on Low-Income Populations." Health Affairs Blog, September 22, 2014. http://healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/

[40] Saucier P, et al. 2012.

[41] January 2014 sanction letter: CMS, "Notice of Immediate Imposition of Intermediate Sanctions (Suspension of Enrollment and Marketing) for Medicare Advantage-Prescription Drug Plan Contract Number: Orange County Health Authority (CalOptima) (H5433)." January 24, 2014. http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/CalOptima-Sanction-01-24-14.pdf; Update at calduals.org, "Alameda and Orange County Updates." November 14, 2014. http://www.calduals.org/2014/11/14/alameda-orange-county-updates/

[42] These and other documents are available at the CMS Financial Alignment Initiative, Information and Guidance for Plans website, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

[43] See CMS, "Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013." March 2012. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf

[44] CMS, "Joint Rate-Setting Process for the Capitated Financial Alignment Model FAQs Updated August 9, 2013." http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

[45] For additional details on state programs for appeals and beneficiary protection, see http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/

[46] Details on the readiness reviews is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ReadinessReviews.html

[47] CMS, "Capitated Financial Alignment Demonstration Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2015." January 2014. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2015_CurrentMMPAnnualRequirements.pdf

[48] Various documents containing CMS guidance for health plans are compiled on the CMS Financial Alignment Initiative, Information and Guidance for Plans website. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This publication (#8717) is available on the Kaiser Family Foundation's website at www.kff.org.

Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*